Excerpts from Dr. Larowe's Deposition

IN THE UNITED STATES DISTRICT COURT

CENTRAL DIVISION

MARTIN CROWSON,

Plaintiff,

vs.

JUDD LAROWE, BRET LYMAN, et al.,

Defendant.

COPY

Case No. 2:15-CV-880-RJS

Judge Tena Campbell

DEPOSITION OF DR. JUDD LAROWE

Taken at the Courtyard Marriott
185 South 1470 East
St. George, Utah

On Wednesday, June 6, 2018
At 9:03 A.M.

Reported by: J. Elizabeth Robison, RPR, CCR

Q. Is there a day of the week that you go out to the jail?

A. Usually Tuesdays, sometimes Thursdays.

Q. Okay. During the time period, from 6-25-2014 to 7-1-2014, do you know what day you went out to the hosp -- or to the prison, if you did go out to the prison?

A. I don't have a clue. I don't remember when Tuesday would have fallen in that year. And in addition, Tuesdays and Thursdays are my current schedule. I've gone Mondays. I've gone Wednesdays. So I'm not even sure on that.

Q. Okay. No record -- do you have a record of when you went to the jail?

A. I do not.

Q. Do you have a memory of seeing Mr. Crowson at all?

A. I don't recall ever seeing Mr. Crowson, either during this time frame or any other time frame.

Q. Okay.

A. I may have. I just have no recollection of it.

Q. When you do see a patient, do you record it in the CorEMR?

A. I do. There is a note for each visit that I perform.

Q. Okay. So if you had seen Mr. Crowson, then your name would appear here, in that third column; is that correct?

A. I have no idea on where it would occur.

Q. Okay.

A. So they have an electronic medical record, and I enter in my visits. Where it would appear or not appear, I don't have a clue.

Q. All right. Have you seen anything in the records, that you've reviewed, that would indicate that you did, personally, see Mr. Crowson?

A. I have seen no records of my personal evaluation of Mr. Crowson.

Q. Okay. On 6-28-14, Mr. Johnson noted that, "The BP," I assume that's blood pressure, "is elevated at this time and reported to MD."

A. I'm sorry. What day?

Q. On 6-28-14, at 2:07 P.M.

A. I don't recall that. So...

Q. Okay.

A. It certainly could have happened. I don't recall.

Q. What's -- in terms of what you would have

A. We deal with this quite routinely.
Q. All right. Let's talk about methamphetamine withdrawals.
If a med -- person who's addicted to methamphetamine goes off of the drug, how long does it take for that to get out of their system?
MR. MCGARRY: Object to the form. Go ahead.
A. Usually 72 hours. Sometimes a little longer.
Q. Okay. As far as these symptoms that you called "psychoses" go, is that associated with methamphetamine withdrawals?
MR. MCGARRY: Same objection.
A. A lot of things are connected with withdrawals. People will be confused quite often during the withdrawal stage. They can be agitated. They can have a multitude of symptoms, including hypertension, diaphoresis, tachypnea, tachycardia.
Q. What's diaphoresis?
A. Sweating.
Q. And the second one, the tachy --
A. Tachypnea is rapid respiratory rate, and tachycardia is rapid pulse rate.
Q. Right. How long do those symptoms last in

withdrawal symptoms from heroin similar to what they are from methamphetamine?

MR. MCGARRY: Object as to form.

A. The withdrawal symptoms to heroin, once again, very nonspecific: Nausea, diaphoresis, tachycardia, tachypnea, elevated blood pressure. And those might last longer than methamphetamine. The half-life for heroin is going to be a little longer.

Q. Okay. And when you say a little bit longer, what's the time period, do you think?

A. I don't know. I couldn't give you a precise opinion on that.

Q. What about alcohol withdrawal symptoms?

A. They can last longer. Usually, the time of onset is within 72 hours of cessation. But especially when you're talking about delirium tremens, that can go on for days and days.

Q. Can it go on for weeks?

A. Not weeks.

Q. Can it start weeks after?

A. No, it cannot.

Q. And by "delirium tremens," what do you mean by that?

A. The DTs, the typical symptoms: Visual

hallucinations, auditory hallucinations, tactile. I won't call them hallucinations. But you can have odd tactile sensations, confusion, agitation. And then pretty much the same symptoms as we've discussed with the others.

Q. Would not knowing what kind of work you had done prior to incarceration be a delirium tremens?

A. That's a pretty --

MR. MCGARRY: Object to form.

A. -- nonspecific --

MR. MCGARRY: Sorry, Judd.

A. Oh.

MR. MCGARRY: Object to form. Go ahead.

A. Okay. That's a pretty nonspecific complaint. So that could be part of that.

Q. Okay. Do you recall receiving any information from Mike Johnson that's not contained in these notes?

A. I don't.

Q. As you reviewed these notes, did you see anything in there that you thought would be specific, as it relates to a delirium tremens?

A. No, I did not. These symptoms are nonspecific. There are a lot of different disease

encephalopathy. Specifically, there is a finding of fetor hepaticus. The breath smells fruity, yeah, oftentimes in these individuals. Sometimes there will be jaundice. They can be quite agitated as well. But once again, those fall under many subheadings. But those are the things you might typically see in that case.

Q. Okay. If you suspect that somebody has metabolic encephalopathy, what's the appropriate course of treatment?

A. The appropriate course of treatment in that case, several things. One, you treat the agitation. Number two, you also would give them either neomycin or lactulose. Those help reduce ammonia levels. Typically, you'd give them thiamine, because anyone with hepatic encephalopathy is usually thiamine deficient. They're also usually deficient in other vitamins, so we typically give them a multi-vitamin. We give them thiamine. You would treat them with lactulose or neomycin. You would treat their agitation as well. You know, those are the main things --

Q. Okay.

A. -- that you would use.

Q. What diagnostic tools do you have

nursing staff and myself are all on board with this -- is: You know, the patient comes first. Whatever we need to do to make sure we protect the patient. So no. If Mike had felt that the patient needed to be transported or thought there was even a question, we would have transported him at that time.

Q. Okay.

A. I'm not going to keep someone in the jail when the appropriate course of action is to have them seen in the emergency room.

Q. Which makes your ability to rely on Mr. Johnson critical; isn't that true?

A. It does. It does.

Q. Outside of the -- I know you don't keep notes of -- or records outside the jail.

Do you have any procedures or protocols for following up on patients, who you know have been having some sort of symptoms, like being dazed and confused?

MR. MCGARRY: Let me just ask for a clarification.

MR. SCHRIEVER: Yeah.

MR. MCGARRY: You mean -- so a patient who is still an inmate, when you say "following up,"

not somebody who's been transferred to the emergency department or been released from the jail, but is sill incarcerated?

MR. SCHRIEVER: Correct, and I can make it more specific.

Q. For example, in this case, Mr. Johnson -- the records indicate that he contacted you on June 28th.

Do you have any kind of tickler system or policies or procedures where on June 29th you would call and say, "Hey, what's going on with Inmate Crowson?"

A. I don't. Mr. Crowson was transported to booking or moved from wherever he was before to the booking area, which is immediately adjacent to medical. And when they are moved to booking, medical will do rounds on them every shift, and I believe the deputies check on them every 30 minutes. And so there's pretty close observation. So that ensures good follow-up. And then if something occurs during their rounds or if they're notified by a deputy, they would give me a call.

Q. Okay. Now, I'm not necessarily familiar with hospital protocol or the way hospitals work.

But you have worked in a hospital; right?

A. Correct.
Q. When you have patients under your care in a hospital, is there a -- is there a time period in which the doctor is going to say, "All right. I need to check up on this patient," or is there -- how did that work?
MR. MCGARRY: Object to form. Incomplete hypothetical.
MR. MYLAR: Join.
A. In a hospitalized patient, you would round on them daily. That's a minimum.
Q. Okay. And that's the doctor is going to round on them daily?
A. Correct.
Q. And then the nurses are there in addition to that; right?
A. Correct.
Q. In the jail system, that's different?
A. It's not a hospital.
Q. Right. But the purpose of putting him in booking was so that he could be under observation; right?
A. Correct.
Q. And so the nurses are there checking on him once per shift at a minimum?

anything in your recollection from speaking with Mr. Johnson that Mr. Crowson was agitated or suffering from agitation?

A. Well, I think the confused part, yes. And if you look at the note on the 29th, he actually looked like he was doing better, 9:43 at that time. So yeah, these symptoms are vague and fit a number of diagnostic criteria. But yeah, he -- I would agree with that, the confusion and that.

Q. Okay. And I want to break this down a little bit, because you say you agree. But I'm not sure what we're agreeing with.

A. I'm sorry.

Q. I want to break this down a little bit more.

A. Yes.

Q. When you use the term "agitation" in relation to alcohol withdrawal symptoms, describe that for me. What does that look like?

A. Oh, it can be a variety of findings. Anywhere from being violent and aggressive to not knowing where you're at, what you're doing, not having a recollection of things that have occurred. You know, the classic seeing spiders on the wall sort of thing. Patients can be terribly

uncooperative during these times. So that's what I would consider to fall under that heading.

Q. Okay. And that's all under the heading of agitation?

A. Yes.

Q. Okay. Like -- and let me -- I'm just asking this. I'm not meaning to argue with you. But like, you said, "Seeing spiders on the wall."

That -- I would consider that a visual hallucination, but does that still fall under the rubric of agitation?

A. I think it's semantics really --

Q. Okay.

A. -- at that point. I mean, agitation is a very broad term.

Q. Okay. And then the hallucinations visually, you gave me the example of spiders climbing on the wall?

A. That's kind of the classic one. Pink elephants or whatever else you want to -- you want to describe. But I've had people think they were ice fishing --

Q. Okay.

A. -- when I would evaluate them. So it can be pretty wild.